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Issue Brief

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Long-Term Care Insurance Partnership: Considerations for Cost-Effectiveness

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Long-term care (LTC) services comprise the largest portion of Medicaid expenditures in most states, serving as a motivator for states to develop innovations that would help hold the line on these expenses.[1] In 1988 the Robert Wood Johnson Foundation (RWJF) supported four states in pioneering new products with Medicaid asset protection to encourage more people to buy long-term care insurance. With the passage of the 2005 Deficit Reduction Act, the Long-Term Care Partnership (LTCP) program has emerged as an option to help states manage long-term expenditures and, at the same time, offer consumers more affordable coverage.[2]

Through LTCP policies, consumers are protected from having to become impoverished in order to qualify for Medicaid. They get access to expedited care assessment and management services, and states avoid the full burden of long-term care costs. Cost-effectiveness — for consumers and public purchasers — is the key rationale behind Partnership programs. Cost-effectiveness, however, depends on the confluence of a variety of factors, including which consumers to target, what policy features will help achieve cost-effectiveness, and the influence of Deficit Reduction Act (DRA) legislation. This brief reviews considerations for states in how to design and market Partnership programs to achieve cost-effectiveness.

This issue brief reviews considerations for states in how to design and market Long-Term Care Partnership programs to achieve cost-effectiveness. It is the third in a series of briefs produced through CHCS' *Long-Term Care Partnership Expansion* project, made possible by the Robert Wood Johnson Foundation.

The Rationale for the Partnership

The Long-Term Care Partnership program offers a creative insurance coverage option that:

- Reduces Medicaid LTC costs by encouraging people at risk for "spend down" (or who would otherwise transfer assets to avoid spending down) to buy LTC insurance instead of relying on Medicaid.

- Rewards consumers by providing "back-end" protection. If policyholders exhaust private coverage and still need LTC they:
  - » Can access Medicaid LTC benefits without meeting the usual asset "spend down" rules; and
  - » May keep $1 of assets for every $1 received in LTC benefits from a Partnership policy; this is referred to as the "asset disregard incentive."

[1] D.I. Shostak and P.A. London. "State Medicaid Expenditures for Long-Term Care 2008-2027," Report prepared by Strategic Affairs Forecasting for America's Health Insurance Plans, September 2008. Available at **http://www.ahip.org/content/default.aspx?docid=24597.**

[2] For background on the Partnership model, see *Long Term Care Partnership Expansion: A New Opportunity for States*. Robert Wood Johnson Foundation Issue Brief, May 2007. Available at **http://www.chcs.org/usr_doc/Long-Term_Care_Partnership_Expansion.pdf**

History of Partnership Cost-Effectiveness

The cost-effectiveness of the Long-Term Care Partnership has been the subject of analysis since its inception. Measuring cost-effectiveness is difficult because the types of behavior changes anticipated can only be determined with certainty through actual experience. In addition, determining whether certain behaviors, such as asset transfers in order to qualify for Medicaid, would have occurred in the absence of a Partnership program is difficult. With long-term care insurance, benefit use usually occurs in the distant future relative to the time of purchase.

It also takes time for the anticipated market changes envisioned through the Partnership (i.e., increased private LTC coverage for people who would otherwise rely on Medicaid) to mature. Together these challenges continue to frustrate states that must justify the Partnership to policymakers by proving value through cost-effectiveness.

In the early stages of Partnership development the National Program Office for the Robert Wood Johnson Foundation's (RWJF) initiative, directed by this author, used the Brookings/ICF Long-Term Care Financing Model to simulate the effects of dollar-for-dollar asset protection on Medicaid spending. The simulation results suggested a seven percentage point drop in Medicaid's share of total long-term care spending by the period 2016-2020 compared to the 1990 baseline.[3] The U.S. Department of Health and Human Services (DHHS) assumed that the Partnership would be at least budget neutral, with an opportunity for savings because:

- Consumers would have a more appealing alternative to transferring assets;
- Care management assistance and preferred provider choices could control use and cost by helping consumers stretch and conserve their insurance dollars;
- Earned income on protected assets would be applied to the cost of care; and
- Predicting the amount of resources consumers will have in the future when they need long-term care is hard and consumers may over insure their assets with increased certainty of protecting at least some of them.

A study by the General Accountability Office (GAO), however, concluded that Medicaid savings were not likely, but that costs to Medicaid were also minimal because "few policyholders are likely to exhaust their benefits and become eligible for Medicaid due to their wealth and having policies that will cover most of their long-term care needs."[4] The GAO report sparked controversy with the original Partnership states, some of which had begun to estimate Medicaid savings using survey data along with actual experience. To help new states prepare their own case for cost-effectiveness it is helpful to review these methods as they reveal some key points of contention to anticipate and address.

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[3] M.R. Meiners and H.L. McKay, "RWJF's Long-Term Care Insurance Partnership Program: Cost-Effectiveness Estimates." National Program Office Technical Assistance Note, October 23, 1991. Available at: **http://www.gmu.edu/departments/chpre/research/PLTC/IncreasingtheMarketforLong-TermCareInsurance.pdf**

[4] Government Accountability Office, Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings, Report # GAO-07-231, May 2007.

The cost-effectiveness model reviewed in the GAO report was developed by David Guttchen, who has served as director for the Connecticut Partnership since 1992. The model, which is also used by California and Indiana, poses the following three survey questions to Partnership policyholders to help establish cost estimates:

- Would you have purchased LTC insurance in the absence of the Partnership?
- Did the Partnership influence your decision to purchase LTC insurance? and
- Why did you decide to purchase LTC insurance? (one of the possible responses is "As an alternative to transferring assets to qualify for Medicaid.").

Depending on the responses, policyholders are categorized as: (1) potential costs to Medicaid; (2) potential savings to Medicaid; and (3) budget neutral. (See "Partnership Cost-Effectiveness Model" sidebar for more details.)

In its analysis, GAO did not use the final two questions citing concerns about them being "ambiguous and speculative." The net effect was that GAO assumed that a larger group (80 percent or more of all purchasers) might generate Medicaid costs because they would have purchased LTC insurance without the Partnership and thereby gain access to Medicaid coverage that they might not otherwise have had. Correspondingly, the group that the GAO assumed might generate Medicaid savings (20 percent or less of purchasers) was considerably smaller than individual state estimates that used all three survey questions.

Other simplifying assumptions in the report also reduced the possibility for cost savings. The GAO chose to assume that consumers do not over insure their assets. This is a major source of potential savings if states effectively use the Partnership asset protection feature to encourage sales to middle-income consumers who are otherwise likely to rely on Medicaid.

The GAO also assumed that consumers generally do not transfer assets to obtain Medicaid coverage. This assumption eliminates the possibility that consumers may prefer to purchase long-term care insurance rather than transfer their assets to become eligible for Medicaid. DHHS questioned the GAO conclusions citing the lack of consideration of estate planning efforts (e.g., asset transfers both before and after eligibility is established).[5]

Marketing Considerations for Cost-Effectiveness

One of the keys to Partnership cost-effectiveness is selling to consumers who are likely to buy LTC insurance because they can see themselves benefiting from the Medicaid asset protection offered with these policies. The group most likely to benefit is middle-income consumers who might otherwise spend down their assets and apply for Medicaid rather than purchasing insurance because they feel they cannot afford enough insurance to protect their savings. To best target these consumers it is helpful to understand the thought process behind a LTC insurance purchase.

[5] Ibid.

Partnership Cost-Effectiveness Model

(Excerpted from the Connecticut LTCP Cost-Effectiveness Model and Formula)

Connecticut surveys long-term care insurance policyholders to determine the reasons behind the purchase and to help estimate the Medicaid cost savings resulting from the Partnership program. The survey asks policy-holders the following questions:

1. Would you have purchased LTC insurance in the absence of the Partnership?
2. Did the Partnership influence your decision to purchase LTC insurance?
3. Why did you decide to purchase LTC insurance?

Based on the answers to these questions, surveyors identify individuals who would and would not have purchased long-term care insurance in the absence of the Partnership and whether those individuals would have otherwise transferred assets to obtain Medicaid benefits. Respondents are then categorized into one of the following groups for the purposes of applying the cost-effectiveness formula.

Purchasers who are potential costs to Medicaid: Individuals who would have purchased LTC insurance in the absence of the Partnership and, therefore, may access Medicaid earlier than if they had purchased a non-Partnership policy.

***Purchasers who are potential savings to Medicaid*:** Individuals who would not have purchased long-term care insurance in the absence of the Partnership or purchased a plan as an alternative to transferring assets. These individuals now have private coverage for services that Medicaid would have previously covered.

Purchasers who are budget neutral to Medicaid: All respondents who do not fall into the categories above are considered budget neutral to Medicaid.

Example of Cost-Effectiveness Formula Calculation*

(Per Connecticut Partnership for Long-Term Care data from April 1, 1992 through June 30, 2007)

Potential Gross Savings

The percentage of survey respondents in the potential savings category (24%) is applied to the amount of benefits that have been paid out through the Connecticut Partnership for Long-Term Care ($46,056,613).

(24%) ($46,056,613) = $11,053,587

This amount is reduced to reflect that Medicaid would have paid at a lower rate – approximately 47% less – so the potential savings are 53% of the above number.

Potential Savings =

(53%) (11,053,587) = $5,858,401

Assuming 3% interest generated from additional applied income generated from protected assets, this number is applied to the total amount of assets protected for people who have accessed Medicaid ($7,284,510).

Interest Generated =

(3%) ($7,284,510) = $218,535

Potential Savings + Interest Generated = Total Potential Savings =

$5,858,401 + $218,535 = $6,076,936

Cost Components

Of the 23% of survey respondents in the potential cost category, only 0.41% (10 respondents) received benefits. This amount is applied to the total amount of benefits paid out from above:

(.0041) ($46,056,613) = $188,832

Potential Net Savings

Total Potential Savings – Cost Component

$6,076,936 - $188,832 = $5,888,104

** NOTE –This analysis does not include the cost to administer the Partnership.*

The Purchase Decision

The cost-effectiveness equation for the Partnership program relies on individual purchase decisions based on the comparative value of coverage for people with different levels of wealth. The decision for the consumer is whether to buy insurance and, if the answer is yes, what features to buy. There are four basic strategies for insuring against long-term care costs that are relevant to this discussion.

- **Self Insurance** (Public): Covers those who are already income eligible or near eligible for Medicaid coverage and who are not in a position to purchase private insurance (either due to cost or pre-existing conditions). They **are likely** to use Medicaid for LTC.

- **Self Insurance** (Private): Refers to those with no insurance principally because they have sufficient resources to cover their own LTC expenses. They are **not likely** to use Medicaid for LTC.

- **Partnership Qualified (PQ) Insurance:** Applies in states with a Partnership program where specific insurance policies have been certified as PQ.

- **Non-Partnership Qualified (NPQ) Insurance:** Applies in states where no Partnership program exists or where selected insurers in Partnership states have chosen to sell NPQ policies.

Individuals are generally self insured by choice (i.e., they can and do cover the cost of care) or because of personal circumstances (e.g., inability to afford meaningful coverage or inability to obtain coverage due to pre-existing health conditions). Long-term care insurance (both PQ and NPQ) falls in the large gap between these two self insurance extremes. To be precise, however, note that individuals purchasing long-term care insurance are still engaging in a limited form of self insurance. Benefit design choices including elimination periods, daily benefit amounts, inflation protection, and length of coverage can easily be translated into a pool of money that is available to pay for covered nursing home or home- and community-based services (i.e., a lifetime maximum benefit). These benefit choices affect not only premiums, but also the out-of-pocket expenses (self insurance) that an insured individual will incur for care. More coverage means less self insurance but higher premiums and vice versa.

When insurance benefits are exhausted, individuals must pay the full cost of care or apply for Medicaid. The Partnership's dollar-for-dollar asset protection feature is an incentive to encourage consumers who are at the lower end of the self insurance continuum to buy insurance so they are better able to deal with the risk of long-term care expenses that exceed their ability to self insure. The following is an example of how asset protection works when policy benefits are exhausted and policyholders apply for Medicaid. In this scenario a Partnership policy with a maximum of $100,000 in benefits is compared to a non-Partnership policy with equal protection.

- NPQ policy – Single person is Medicaid eligible with $2,000 or less in assets (i.e., additional assets above $2,000 must be spent down before becoming Medicaid eligible). The state can also recover assets over $2,000 from the estate after death.

- PQ policy – Single person eligible for Medicaid with $102,000 in assets because of dollar-for-dollar asset protection. All of these assets are exempt from estate recovery.

Even with a PQ policy, a consumer must spend down assets above $102,000 to become Medicaid eligible. So if someone underinsures their assets and receives care that exceeds their insurance they will need to spend some of their assets to get to the protected level. Also, income requirements under Medicaid cannot be waived so all Medicaid applicants regardless of LTC policy type must have incomes below state limits to qualify for benefits. Income above the limit must be devoted to the cost of care.

Partnership asset spend down and income rules are important to cost-effectiveness considerations. Assets can generate income, and higher amounts of assets tend to generate higher income. The rules requiring beneficiaries to apply income to the cost of care means that those with higher resources (income plus assets) are less likely to require full Medicaid payment for their long-term care services. The fact that the Partnership protects assets that might otherwise be spent down increases the likelihood of those assets generating income to cover some of what Medicaid otherwise would have had to cover.

Targeting the "Middle-Middle" Market

For people in the middle of the income and asset spectrum, the decision to buy long-term care insurance is not easy to make. This brief refers to these consumers as the "middle-middle" (MM) resources group – describing people whose monthly pension and savings provide a comfortable retirement *unless* long-term care is needed. One can construe the range of resource levels within the MM group to be quite large. For example, the GAO Partnership study analyzed three income ranges and four asset ranges.[6] Within GAO's broad categories, the MM group includes individuals with monthly incomes between $1,000-$5,000 and total assets of $100,000-$350,000. Whatever specific criteria are used to establish the MM group, it is these potential LTC insurance purchasers who would most benefit from Partnership policies. This is also the group that enhances states' ability to achieve cost-effectiveness in an LTCP program, particularly those at the lower income/asset range of the MM group.

In its review of assumptions, the GAO report acknowledges that "if individuals over insure their assets, those who finance their long-term care using Partnership policies could represent a source of savings for Medicaid when compared with those who self-finance their care."[7] MM populations with fewer resources are more likely to over insure their assets and save Medicaid money. MM purchasers with greater resources are more likely to over insure their average risk (2-3 years of nursing home or alternative care), but underinsure their assets. These two statements are compatible in that the average risk can be assumed to be generally the same for all populations and it is likely that those at the higher end of the resource continuum will seek to at least cover the average risk, while those with less resources may not be able to afford the coverage levels necessary to insure the average risk.

The dollar-for-dollar asset protection is more valuable to MM group purchasers with fewer resources because if they try to insure average risk, they are more likely to cover an amount that actually is greater than necessary to protect their assets. In this scenario, purchasers with

[6] Ibid.
[7] Ibid.

fewer resources use the insurance to pay for care rather than using their assets. The Partnership asset protection feature is necessary to make this work because those in the MM group with fewer resources can probably only afford a benefit package that would cover less than the average risk. The front-end years of coverage are the most expensive since they are most likely to be used. If MM purchasers with fewer resources experience anything near the average risk, without Partnership protection they would be spending down the very assets they were looking to depend on for other purposes. Without the Partnership those MM consumers will tend to totally self insure; reasoning that the average risk would impoverish them anyway, so why pay premiums.

People at the low resource end of the MM group who self insure are relatively more likely to end up on Medicaid if they need long-term care. Therein lies the cost-effectiveness trade-off for states. While states risk letting some people on Medicaid sooner, this is balanced by the incentive of Partnership asset protection that can get more people to explicitly prepare for long-term care with insurance. This coverage increases the likelihood that MM purchasers will pay for more of their own care than they would without insurance. If more people avoid Medicaid altogether or at least use less Medicaid than they would otherwise, the Partnership incentive is cost-effective for states.

States should be targeting Partnership program outreach messages to consumers at the lower resource tier of the "middle-middle" group who are potentially most in need of special assistance in preparing for long-term care.

People in the MM market with greater resources are less likely to use dollar-for-dollar asset protection. The more resources people have the more likely they are to over insure their average risk even if they underinsure their assets. That is, they will typically buy enough insurance so they more than cover the average risk (e.g., 4-5 years equivalent of nursing home care when the average risk of LTC use is in the range of 2-3 years). Consumers with more wealth are willing to sacrifice a little of it for the certainty of avoiding high LTC costs. Also, each additional year of coverage is increasingly less expensive since the chances of needing care beyond the average risk decrease significantly, so buying more years of coverage looks economical. Research shows that, as of 2005, individuals with annual incomes above $25,000 purchase coverage durations of, on average, 5.1 to 5.4 years. Only those with incomes below $25,000 purchase a shorter average duration of 3.6 years.[8]

Under the rules of the Partnership, people in the MM group with greater resources either need to buy more insurance to cover their assets *or* they will need to spend down extra assets to the Partnership-protected level. In either case, for those with greater resources in the MM group the amount of insurance or self insurance potential tends to meet or exceed their likely need for coverage. When this is the case, those consumers are not likely to ever need Medicaid. Thus, states should be targeting Partnership program outreach messages to consumers at the lower resource tier of the MM group who are potentially most in need of special assistance in preparing for LTC.

Further Market Segmentation Considerations

The MM market with greater income/assets is important to the insurance industry since those purchasers comprise the bulk of the current market. However, high-end sales are not the primary priority for states looking to achieve cost-effective Partnership programs (i.e., high-end sales are likely to be budget neutral since many higher asset/income individuals would not qualify for Medicaid even under a dollar-for-dollar asset protection model).

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[8] LifePlans, Inc., "Who Buys Long-Term Care Insurance: A 15 Year Study of Buyers and Non Buyers, 1990-2005." Report prepared for America's Health Insurance Plans., April 2007. **http://www.ahipresearch.org/PDFs/LTC_Buyers_Guide.pdf**

In an odd way this is good news for new Partnership states because their primary target, individuals in the MM group with fewer income/assets, is currently at a baseline of near zero sales. Any new sales to the lower end of the MM market can be seen as contributing to the cost-effectiveness of the Partnership. New sales of Partnership policies at higher ends of the market may also take place, but the total number of these sales must exceed existing sales of non-Partnership qualified policies to justify inclusion in cost-effectiveness calculations.

Without the Partnership's asset protection feature, consumers would need to buy more insurance to accomplish the same level of protection. The effect of the Partnership on this problem was the subject of a paper by Goss and Meiners, who employed two criteria to estimate the potential market for LTC insurance with and without asset protection. First, the policy had to produce a 50 percent reduction in the lifetime risk of losing half (or more) of the starting assets. In addition, annual premiums at issue age could not exceed about five percent of income. Self insurance was compared to insurance with and without the Partnership asset protection feature. In the age groups examined (65-74), it was estimated that the proportion of qualifying households increased from under 18 percent (3.9 million) without the Partnership to over 35 percent (7.7 million) with the Partnership, nearly a 100 percent increase in the potential market.[9] The effect was much stronger for individuals in the MM group with fewer resources.

Program Design and Medicaid Eligibility Considerations for Cost-Effectiveness

Reaching MM consumers requires policy options that are both affordable and attractive to that market. The growth of the Partnership post-DRA provides a new opportunity for coverage features that are cost-effective for states and attractive to consumers because of the asset protection feature. There are also issues around the conversion of insurance policies (NPQ to PQ) and a number of Medicaid eligibility rules changes that affect the cost-effectiveness equation for states.

Solid Front-end Coverage

The concept of solid front-end coverage has emerged as an option to entice MM consumers with fewer resources to purchase LTC policies, and also enhance cost-effectiveness for states. Solid front-end coverage (sometimes referred to as "Short and fat") is defined as insurance covering the equivalent of as little as 1-3 years worth of benefits, but designed to cover substantial amounts of the actual cost of care during the benefit period. The rationale behind this approach is that Partnership policies that put premium dollars into front-end features help protect consumer assets. States should emphasize certain insurance policy features to accomplish cost-effectiveness while providing attractive solid front-end policies for consumers with fewer resources. Recall that within the context of owning LTC insurance, self insurance occurs when:

[9] S.C. Goss and M.R. Meiners. "Increasing the Market for Long-Term Care Insurance by Reducing the Risk of Impoverishment: The Effect of the 'Dollar-for-Dollar' Partnership Model" Presented at the 1994 Annual Meeting of the American Economic Association, Boston, MA, January 1994. Available at: **http://www.gmu.edu/departments/chpre/research/PLTC/IncreasingtheMarketforLong-TermCareInsurance.pdf.**

- There is an elimination period before benefits begin;
- The daily benefit is less than the actual daily cost of care;
- The benefit does not keep up with inflation; and
- The lifetime benefit amount needed is greater than the amount of care covered by insurance.

The Partnership helps alleviate consumer concerns about the last of these self-insurance considerations so more attention can be focused on the others.

To make the solid front-end concept work for MM consumers, states should encourage insurers to offer a range of coverage durations starting with as little as one year's worth of benefits. Offering a range of coverage periods is consistent with the idea of a "pool of dollars" benefit approach that is commonly the way LTC insurance is sold. That is, the number of days covered (e.g., 365 days) multiplied by the amount of daily benefit (e.g., $200 per day) comprises the basic starting pool of dollars ($73,000) that a LTC policy will pay out if care is needed today. Inflation protection adjusters are then applied, increasing the pool over time. If policyholders use less than the daily benefit while in claim, the remainder stays in the pool and extends the period during which the insurance will pay, increasing cost-effectiveness by reducing the likelihood of needing Medicaid.

With the basic pool of dollars benefit structure, the decision on what features comprise the "solid" part should come first. It is usually better for consumers with limited assets to purchase a shorter elimination period and to make sure that the daily cost of care is covered and that inflation protection keeps up with the increasing cost of care. These features may increase premiums, but that increase is offset by the fact that consumers can protect assets that otherwise might have been spent on LTC. Price sensitive consumers, especially those in the MM market can reduce premiums and retain maximum asset protection by adjusting benefit length, "short or long," based on their ability to pay premiums. Consumers with more assets to protect might choose to accept higher cost sharing features to reduce premiums, assuming that their assets can more comfortably be applied toward meeting out-of-pocket LTC expenses.

NPQ to PQ Conversions

In launching their Partnership programs states must consider rules for converting existing NPQ policies to PQ policies. This is directly relevant to cost-effectiveness considerations, though the benefits of the Partnership may cause states to overlook this issue. Granting Partnership status to existing policies erodes the potential for cost-effectiveness since those purchasers did not need the Partnership incentive to purchase coverage. Granting asset protection after the fact puts the state at risk of incurring some Medicaid expenditures for which it may not have otherwise been responsible. A possible exception occurs where someone with existing coverage that lacks inflation protection exchanges their coverage for a PQ policy with inflation protection.

Congress restricted exchanges to policies that meet the DRA requirements. States and insurers each have their own positions on what this means and how to best implement exchanges. Insurers are concerned that sales might be delayed if consumers wait for a state

Partnership program to be operational. They prefer that there be some previous point in time from which they could guarantee purchasers that policies would qualify for exchange. Some states were equally concerned about equity issues for consumers who purchased policies prior to a specific point in time. It is relatively easy to give Partnership protections to recent purchases that meet the Partnership rules of a state, but that happened just before the official launch. States have done so using a number of conversion look-back dates (e.g., passage of the DRA, passage of state implementation legislation, and implementation of LTC insurance rate stabilization). Conversions of older policies are more problematic for insurers to do without significant new work and could also erode some cost-effectiveness for states.

Medicaid Eligibility Rule Changes

Additional rules were introduced in the 2005 DRA that may influence cost-effectiveness considerations for Partnership programs.[10] One is the exclusion of those with home equity in excess of $500,000 (up to $750,000 at state discretion). That is, if a person has more than $500,000 in home equity, he or she would need to free up that equity and spend it down before the Medicaid eligibility process can proceed. However, this does not apply if a child or spouse resides in the home. The DRA also lengthened the asset transfer look-back period for establishing Medicaid eligibility from three to five years and changed the penalty start date from date of transfer to date of eligibility. It also requires disclosure of annuities and that the state is named as a beneficiary to cover Medicaid expenditures.

Each of these changes has a somewhat different effect on Partnership cost-effectiveness calculations. The home equity limit is totally new and creates a measurable barrier to Medicaid access for those with significant wealth whether or not they have a PQ policy. Asset transfer rules existed before, but they were not seen as effective in most states and certainly not by the original Partnership states. Asset transfers allowed people in the MM group and above to obtain Medicaid coverage even though they could have paid for at least some of their care. Indeed, survey work done in the California, Connecticut, and New York to assess this difficult-to-document phenomenon indicated that 24-27 percent of Partnership buyers said they otherwise would have transferred assets.[11] The new asset transfer rules are more difficult to circumvent and should help eliminate this controversial element from cost-effectiveness calculations. Making the Partnership available to all purchasers, no matter where they land on the resource continuum, also serves as a reasonable alternative to asset transfers.

Conclusion

Currently, the lower segment of the MM market is largely uninsured for LTC. The cost-effectiveness of state Partnership programs depends heavily on the development and sale of LTC insurance to the lower end of the MM market. The Partnership asset protection feature provides considerable value added to the lower MM group. By knowing that assets beyond the normal Medicaid allowance can be preserved, people with middle and modest incomes have more of an incentive to save. This has the potential to significantly increase that segment of the market in both absolute and relative numbers as compared to the current patterns of LTC insurance purchasers. This will help tip the cost-effectiveness calculations

[10] J. Stone, "Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery, as Modified by the Deficit Reduction Act of 2005," CRS Report for Congress, April, 2006.
[11] GAO, op. cit.

toward the side of saving money for Medicaid as more people see value in preparing for this risk through insurance.

Whenever LTC insurance benefits exceed the assets that would have been available to pay for care when needed, there is the potential for state cost savings. "Solid front-end" policies need to be made available for periods as short as one year of LTC services with gradations up to at least five years. This would allow consumers to obtain robust protection and adjust the length of that protection based on affordability and risk aversion. Partnership programs can work with insurers to offer these policy designs allowing consumers to purchase coverage equal to the amount of assets they want to protect while at the same time helping states achieve cost savings. The availability of these policies will draw even more MM consumers to the Partnership, further enhancing the probability of cost-effectiveness.

About the Author

Mark R. Meiners, PhD, is a Professor of Administration and Health Policy in the College of Health and Human Services at George Mason University. Among his noteworthy recent accomplishments is his leadership of the Robert Wood Johnson Foundation (RWJF) Medicare/Medicaid Integration Program, an initiative designed to help states develop new systems of care that better coordinate acute and long-term care. In addition he has led the Partnership for Long-Term Care since its beginning in 1987.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy resource center dedicated to improving health care quality and cost-effectiveness for low-income populations and people with chronic illnesses and disabilities. CHCS works directly with states and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs.

Resources for States

The *Long-Term Care Partnership Expansion* project, coordinated by the Center for Health Care Strategies, is providing 18 states with extensive technical assistance to help develop Partnership programs. This brief is one in a series of technical assistance resources that CHCS will make available to help additional states design effective long-term care strategies.

For information about state activities and a library of resources, visit **www.chcs.org**.

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